



# **Commonwealth of Kentucky KY Medicaid**

## **Provider Billing Instructions for Title V Services Provided By The Department for Community Based Services Provider Type – 23**

Version 4.9

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## Document Change Log

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2.4	02/23/2007	Ann Murray	Revised according comment log Walkthrough. v2.0 – 2.4 are actually the same as revisions were made back-to-back and no publication

Document Version	Date	Name	Comments
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4.8	02/01/2017	Vicky Hicks	Added “Disclaimer: The Billing Instructions Form Locator information enclosed are for the use of paper claim submission only. For Electronic claim submission information, please utilize the Companion Guides found at <a href="http://www.kymmis.com">www.kymmis.com</a> under Companion Guides and EDI Guides.” Approved by Charles Douglass, DMS, 2/1/17 Added information for form locators 17 and 17B regarding Referring and Ordering Providers. Approved by Charles Douglass, DMS, 2/8/2017
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# 1 General

## 1.1 Introduction

**Disclaimer: The Billing Instructions Form Locator information enclosed are for the use of paper claim submission only. For Electronic claim submission information, please utilize the Companion Guides found at [www.kymmis.com](http://www.kymmis.com) under Companion Guides and EDI Guides.**

These instructions are intended to assist persons filing claims for services provided to Kentucky Medicaid Members. Guidelines outlined pertain to the correct filing of claims and do not constitute a declaration of coverage or guarantee of payment.

Policy questions should be directed to the Department for Medicaid Services (DMS). Policies and regulations are outlined on the DMS website at:

<https://chfs.ky.gov/agencies/dms/Pages/default.aspx>

Fee and rate schedules are available on the DMS website at:

<https://chfs.ky.gov/agencies/dms/Pages/feesrates.aspx>

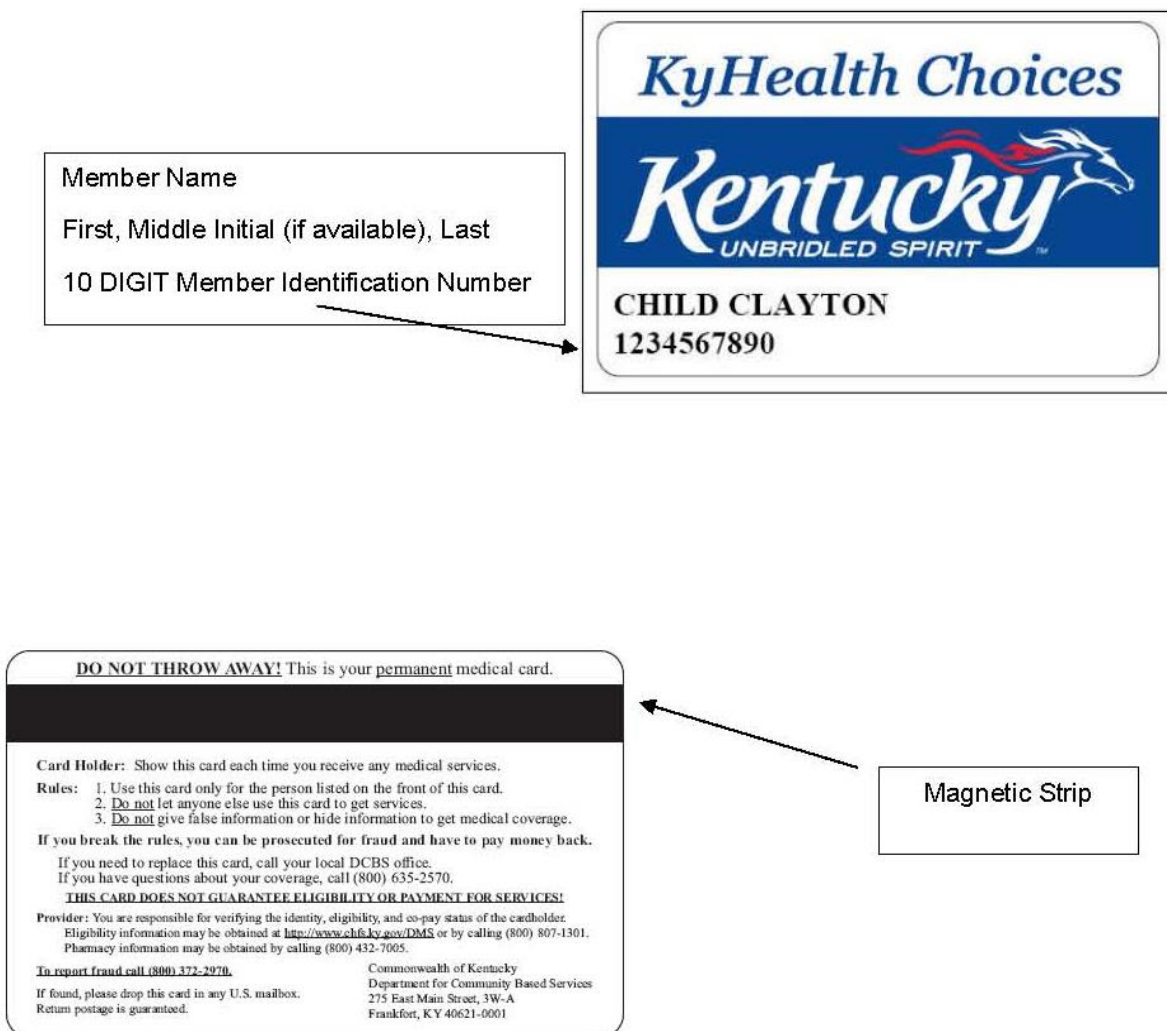
## 1.2 Member Eligibility

Members should apply for Medicaid eligibility through kynect ([kyenroll.ky.gov](http://kyenroll.ky.gov)), by phone at 1-855-4kynect (1-855-459-6328), or in person at their local Department for Community Based Services (DCBS) office. Members with questions or concerns can contact Member Services at 1-800-635-2570, Monday through Friday. This office is closed on holidays.

The primary identification for Medicaid-eligible members is the Kentucky Medicaid card. This is a permanent plastic card issued when the Member becomes eligible for Medicaid coverage. The name of the member and the member's Medicaid identification (ID) number are displayed on the card. The provider is responsible for checking identification and verifying eligibility before providing services.

**NOTE: Payment cannot be made for services provided to ineligible members. Possession of a Member Identification card does not guarantee payment for all medical services.**

### 1.2.1 Plastic Swipe KY Medicaid Card



Through a vendor of your choice, the magnetic strip can be swiped to obtain eligibility information.

Providers who wish to utilize the card's magnetic strip to access eligibility information may do so by contracting with one of several vendors.



## **1.2.2 Member Eligibility Categories**

### **1.2.2.1 QMB and SLMB**

Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiaries (SLMB) are Members who qualify for both Medicare and Medicaid. In some cases, Medicaid may be limited. QMB Members have Medicare and full Medicaid coverage, as well. QMB-only Members have Medicare, and Medicaid serves as a Medicare supplement only. A Member with SLMB does not have Medicaid coverage; Kentucky Medicaid pays a "buy-in" premium for SLMB Members to have Medicare, but offers no claims coverage.

### **1.2.2.2 Managed Care Partnership**

Medical benefits for persons whose care is overseen by a Managed Care Organization (MCO) are similar to those of Kentucky Medicaid, but billing procedures and coverage of some services may differ. Providers with MCO questions should contact the respective MCO provider services: Passport Health Plan at 1-800-578-0775, WellCare of Kentucky at 1-877-389-9457, Humana Caresource at 1-855-852-7005, Anthem Blue Cross Blue Shield at 1-800-880-2583, or Aetna Better Health of KY at 1-855-300-5528.

### **1.2.2.3 KCHIP**

The Kentucky Children's Health Insurance Program (KCHIP) provides coverage to children through age 18 who have no insurance and whose household income meets program guidelines. Children with KCHIP III are eligible for all Medicaid-covered services except Non-Emergency Transportation and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Special Services. Regular KCHIP children are eligible for all Medicaid-covered services.

For more information, access the KCHIP website at <http://kidshealth.ky.gov/en/kchip>.

### **1.2.2.4 Presumptive Eligibility**

Presumptive Eligibility (PE) is a program that offers certain individuals and pregnant women temporary medical coverage. A treating physician or hospital may issue an Identification Notice to an individual if it is determined that the individual meets the criteria as described below. PE benefits are in effect up to 60 days from the date the Identification Notice is issued, or upon denial or issuance of Medicaid. The 60 days includes current month through end of the next month. This short-term program is intended to allow financially needy individuals to have access to medical services while they are completing the application process for full Medicaid benefits.

Reimbursement for services is different for presumptively eligible individuals depending on the method by which eligibility is granted. The two types of PE are as follows:

- PE for pregnant women
- PE for hospitals

#### **1.2.2.4.1 PE for Pregnant Women**

##### **1.2.2.4.1.1 Eligibility**

A determination of presumptive eligibility for a pregnant woman shall be made by a qualified provider who is enrolled as a Kentucky Medicaid provider in one of the following categories:

1. A family or general practitioner;
2. A pediatrician;
3. An internist;
4. An obstetrician or gynecologist;
5. A physician assistant;
6. A certified nurse midwife;
7. An advanced practice registered nurse;
8. A federally-qualified health care center;
9. A primary care center;
10. A rural health clinic
11. A local health department

Presumptive eligibility shall be granted to a woman if she:

1. Is pregnant;
2. Is a Kentucky resident;
3. Does not have income exceeding 195 percent of the federal poverty level established annually by the United States Department of Health and Human Services;
4. Does not currently have a pending Medicaid application on file with the DCBS;
5. Is not currently enrolled in Medicaid;
6. Has not been previously granted presumptive eligibility for the current pregnancy; and
7. Is not an inmate of a public institution

#### **1.2.2.4.1.2 Covered Services**

Covered services for a presumptively eligible pregnant woman shall be limited to ambulatory prenatal services delivered in an outpatient setting and shall include:

1. Services furnished by a primary care provider, including:
  - a. A family or general practitioner;
  - b. A pediatrician;
  - c. An internist;
  - d. An obstetrician or gynecologist;

- e. A physician assistant;
  - f. A certified nurse midwife; or
  - g. An advanced practice registered nurse;
- 2. Laboratory services;
- 3. Radiological services;
- 4. Dental services;
- 5. Emergency room services;
- 6. Emergency and nonemergency transportation;
- 7. Pharmacy services;
- 8. Services delivered by rural health clinics;
- 9. Services delivered by primary care centers, federally-qualified health centers, and federally-qualified health center look-alikes; or
- 10. Primary care services delivered by local health departments.

#### **1.2.2.4.2 PE for Hospitals**

##### **1.2.2.4.2.1 Eligibility**

A determination of presumptive eligibility can be made by an inpatient hospital participating in the Medicaid program using modified adjusted gross income for an individual who:

- 1. Does not have income exceeding:
  - a. 138 percent of the federal poverty level established annually by the United States Department of Health and Human Services; or
  - b. 200 percent of the federal poverty level for children under age one and 147 percent of the federal poverty level for children ages 1-5 as established annually by the United States Department of Health and Human Services, if the individual is a targeted low-income child;
- 2. Does not currently have a pending Medicaid application on file with the DCBS;
- 3. Is not currently enrolled in Medicaid; and
- 4. Is not an inmate of a public institution.

##### **1.2.2.4.2.2 Covered Services**

Covered services for a presumptively eligible individual who meet the income guidelines above shall include:

- 1. Services furnished by a primary care provider, including:
  - a. A family or general practitioner;

- b. A pediatrician;
  - c. An internist;
  - d. An obstetrician or gynecologist;
  - e. A physician assistant;
  - f. A certified nurse midwife; or
  - g. An advanced practice registered nurse;
- 2. Laboratory services;
  - 3. Radiological services;
  - 4. Dental services;
  - 5. Emergency room services;
  - 6. Emergency and nonemergency transportation;
  - 7. Pharmacy services;
  - 8. Services delivered by rural health clinics;
  - 9. Services delivered by primary care centers, federally-qualified health centers and federally-qualified health center look-alikes;
  - 10. Primary care services delivered by local health departments; or
  - 11. Inpatient or outpatient hospital services provided by a hospital.

#### **1.2.2.5 Breast & Cervical Cancer Treatment Program**

The Breast & Cervical Cancer Treatment Program (BCCTP) offers Medicaid coverage to women who have a confirmed cancerous or pre-cancerous condition of the breast or cervix. In order to qualify, women must be screened and diagnosed with cancer by the Kentucky Women's Cancer Screening Program, be between the ages of 21 and 65, have no other insurance coverage, and not reside in a public institution. The length of coverage extends through active treatment for the breast or cervical cancer condition. Those members receiving Medicaid through BCCTP are entitled to full Medicaid services. Women who are eligible through BCCTP do not receive a Medicaid card for services. The enrolling provider will provide a printed document that is to be used in place of a card.

#### **1.2.3 Verification of Member Eligibility**

This section covers:

- Methods for verifying eligibility;
- How to verify eligibility through an automated 800 number function;
- How to use other proofs to determine eligibility; and
- What to do when a method of eligibility is not available.

### 1.2.3.1 Obtaining Eligibility and Benefit Information

Eligibility and benefit information is available to providers via the following:

- Voice Response Eligibility Verification (VREV) available 24 hours/7 days a week at 1-800-807-1301;
- KY HealthNet at <https://home.kymmis.com>;
- The Department for Medicaid Services, Member Eligibility Branch at 1-800-635-2570, Monday through Friday, except holidays.

#### 1.2.3.1.1 Voice Response Eligibility Verification (VREV)

DXC Technology maintains a VREV system that provides member eligibility verification, as well as information regarding third party liability (TPL), Managed Care, PRO review, Card Issuance, Co-pay, provider check write, and claim status.

The VREV system generally processes calls in the following sequence:

1. Greet the caller and prompt for mandatory provider ID.
2. Prompt the caller to select the type of inquiry desired (eligibility, TPL, Managed Care, PRO reviews, Card Issuance, Co-pay, provider check write, claim status, etc.).
3. Prompt the caller for the dates of service (enter four digit year, for example, MMDDCCYY).
4. Respond by providing the appropriate information for the requested inquiry.
5. Prompt for another inquiry.
6. Conclude the call.

This system allows providers to take a shortcut to information. Users may key the appropriate responses (such as provider ID or Member ID) as soon as each prompt begins. The number of inquiries is limited to five per call. The VREV spells the member name and announces the dates of service. Check amount data is accessed through the VREV voice menu. The Provider's last three check amounts are available.

#### 1.2.3.1.2 KY HealthNet Online Member Verification

KY HealthNet online access can be obtained at <https://home.kymmis.com>. The KY HealthNet website is designed to provide real-time access to member information. Providers can download a User Manual to assist providers in system navigation. Providers with suggestions, comments, or questions, should contact the DXC Technology Electronic Claims Department at [KY\\_EDH\\_Helpdesk@dx.com](mailto:KY_EDH_Helpdesk@dx.com) or 1-800-205-4696.

All Member information is subject to HIPAA privacy and security provisions, and it is the responsibility of the provider and the provider's system administrator to ensure all persons with access understand the appropriate use of this data. It is suggested that providers establish office guidelines defining appropriate and inappropriate uses of this data.

## **2 Electronic Data Interchange (EDI)**

Electronic Data Interchange (EDI) is structured business-to-business communications using electronic media rather than paper.

### **2.1 How to Get Started**

All Providers are encouraged to utilize EDI rather than paper claims submission. To become a business-to-business EDI Trading Partner or to obtain a list of Trading Partner vendors, contact the DXC Technology Electronic Data Interchange Technical Support Help Desk at:

DXC Technology  
P.O. Box 2100  
Frankfort, KY 40602-2016  
1-800-205-4696

Help Desk hours are between 7:00 a.m. and 6:00 p.m. Monday through Friday, except holidays.

### **2.2 Format and Testing**

All EDI Trading Partners must test successfully with DXC Technology and have Department for Medicaid Services (DMS) approved agreements to bill electronically before submitting production transactions. Contact the EDI Technical Support Help Desk at the phone number listed above for specific testing instructions and requirements.

### **2.3 ECS Help**

Providers with questions regarding electronic claims submission may contact the EDI Help desk.

### **3 KY HealthNet**

The KY HealthNet website allows providers to submit claims online via a secure, direct data entry function. Providers with internet access may utilize the user-friendly claims wizard to submit claims, in addition to checking eligibility and other helpful functions.

#### **3.1 How to Get Started**

All Providers are encouraged to utilize KY HealthNet rather than paper claims submission. To become a KY HealthNet user, contact our EDI helpdesk at 1-800-205-4696, or click the link below.

<http://www.chfs.ky.gov/dms/kyhealth.htm>

#### **3.2 KY HealthNet Companion Guides**

Field-by-field instructions for KY HealthNet claims submission are available at:

<http://www.kymmis.com/kymmis/Provider%20Relations/KyHealthNetManuals.aspx>

## **4 General Billing Instructions for Paper Claim Forms**

### **4.1 General Instructions**

The Department for Medicaid Services is mandated by the Centers for Medicare and Medicaid Services (CMS) to use the appropriate form for the reimbursement of services. Claims may be submitted on paper or electronically.

### **4.2 Imaging**

All paper claims are imaged, which means a digital photograph of the claim form is used during claims processing. This streamlines claims processing and provides efficient tools for claim resolution, inquiries, and attendant claim related matters.

By following the guidelines below, providers can ensure claims are processed as they intend:

- USE BLACK INK ONLY;
- Do not use glue;
- Do not use more than one staple per claim;
- Press hard to guarantee strong print density if claim is not typed or computer generated;
- Do not use white-out or shiny correction tape; and,
- Do not send attachments smaller than the accompanying claim form.

### **4.3 Optical Character Recognition**

Optical Character Recognition (OCR) eliminates human intervention by sending the information on the claim directly to the processing system, bypassing data entry. OCR is used for computer generated or typed claims only. Information obtained mechanically during the imaging stage does not have to be manually typed, thus reducing claim processing time. Information on the claim must be contained within the fields using font 10 as the recommended font size in order for the text to be properly read by the scanner.



## 5 Additional Information and Forms

### 5.1 Claims with Dates of Service More than One Year Old

In accordance with federal regulations, claims must be received by Medicaid no more than 12 months from the date of service, or six months from the Medicare or other insurance payment date, whichever is later. "Received" is defined in 42 CFR 447.45 (d) (5) as "The date the agency received the claim as indicated by its date stamp on the claim."

Kentucky Medicaid includes the date received in the Internal Control Number (ICN). The ICN is a unique number assigned to each incoming claim and the claim's related documents during the data preparation process. Refer to Appendix A for more information about the ICN.

For claims more than 12 months old to be considered for processing, the provider must attach documentation showing timely receipt by DMS or DXC Technology and documentation showing subsequent billing efforts, if any.

To process claims beyond the 12 month limit, you must attach to each claim form involved, a copy of a Claims in Process, Paid Claims, or Denied Claims section from the appropriate Remittance Statement no more than 12 months old, which verifies that the original claim was received within 12 months of the service date.

Additional documentation that may be attached to claims for processing for possible payment is:

- A screen print from KY HealthNet verifying eligibility issuance date and eligibility dates must be attached behind the claim;
- A screen print from KY HealthNet verifying filing within 12 months from date of service, such as the appropriate section of the Remittance Advice or from the Claims Inquiry Summary Page (accessed via the Main Menu's Claims Inquiry selection);
- A copy of the Medicare Explanation of Medicare Benefits received 12 months after service date but less than six months after the Medicare adjudication date; and,
- A copy of the commercial insurance carrier's Explanation of Benefits received 12 months after service date but less than six months after the commercial insurance carrier's adjudication date.

### 5.2 Retroactive Eligibility (Back-Dated) Card

Aged claims for Members whose eligibility for Medicaid is determined retroactively may be considered for payment if filed within one year from the eligibility issuance date. Claim submission must be within 12 months of the issuance date. A copy of the KY HealthNet card issuance screen must be attached behind the paper claim.

### 5.3 Unacceptable Documentation

Copies of previously submitted claim forms, providers' in-house records of claims submitted, or letters detailing filing dates are not acceptable documentation of timely billing. Attachments must prove the claim was received in a timely manner by DXC Technology.

## 5.4 Third Party Coverage Information

### 5.4.1 Commercial Insurance Coverage (this does NOT include Medicare)

When a claim is received for a Member whose eligibility file indicates other health insurance is active and applicable for the dates of services, and no payment from other sources is entered on the Medicaid claim form, the claim is automatically denied unless documentation is attached.

### 5.4.2 Documentation That May Prevent a Claim from Being Denied for Other Coverage

The following forms of documentation prevent claims from being denied for other health insurance when attached to the claim.

1. Remittance statement from the insurance carrier that includes:

- Member name;
- Date(s) of service;
- Billed information that matches the billed information on the claim submitted to Medicaid; and,
- An indication of denial or that the billed amount was applied to the deductible.

**NOTE: Rejections from insurance carriers stating “additional information necessary to process claim” is not acceptable.**

2. Letter from the insurance carrier that includes:

- Member name;
- Date(s) of service(s);
- Termination or effective date of coverage (if applicable);
- Statement of benefits available (if applicable); and,
- The letter must have the signature of an insurance representative, or be on the insurance company's letterhead.

3. Letter from a provider that states they have contacted the insurance company via telephone. The letter must include the following information:

- Member name;
- Date(s) of service;
- Name of insurance carrier;
- Name of and phone number of insurance representative spoken to or a notation indicating a voice automated response system was reached;
- Termination or effective date of coverage; and,
- Statement of benefits available (if applicable).

4. A copy of a prior remittance statement from an insurance company may be considered an acceptable form of documentation if it is:

- For the same Member;
- For the same or related service being billed on the claim; and,
- The date of service specified on the remittance advice is no more than six months prior to the claim's date of service.

**NOTE: If the remittance statement does not provide a date of service, the denial may only be acceptable by DXC Technology if the date of the remittance statement is no more than six months from the claim's date of service.**

5. Letter from an employer that includes:

- Member name;
- Date of insurance or employee termination or effective date (if applicable); and,
- Employer letterhead or signature of company representative.

#### **5.4.3 When there is no response within 120 days from the insurance carrier**

When the other health insurance has not responded to a provider's billing within 120 days from the date of filing a claim, a provider may complete a TPL Lead Form. Write "no response in 120 days" on either the TPL Lead Form or the claim form, attach it to the claim and submit it to DXC Technology. DXC Technology overrides the other health insurance edits and forwards a copy of the TPL Lead form to the TPL Unit. A member of the TPL staff contacts the insurance carrier to see why they have not paid their portion of liability.

#### **5.4.4 For Accident and Work Related Claims**

For claims related to an accident or work related incident, the provider should pursue information relating to the event. If an employer, individual, or an insurance carrier is a liable party but the liability has not been determined, claims may be submitted to DXC Technology with an attached letter containing any relevant information, such as, names of attorneys, other involved parties and/or the Member's employer to:

DXC Technology  
ATTN: TPL Unit  
P.O. Box 2107  
Frankfort, KY 40602-2107

**5.4.4.1 TPL Lead Form**

DXC Technology

*DXC Technology  
Attention: TPL Unit  
P.O. Box 2107  
Frankfort, KY 40602-2107*

**Third Party Liability Lead Form**

Provider Name: \_\_\_\_\_ Provider #: \_\_\_\_\_  
Member Name: \_\_\_\_\_ Member #: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
From Date of Service: \_\_\_\_\_ To Date of Service: \_\_\_\_\_  
Date of Admission: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_  
Insurance Carrier Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
Date Claim was Filed with Insurance Carrier: \_\_\_\_\_

Please check the one that applies:

\_\_\_\_\_ No Response in over 120 Days  
\_\_\_\_\_ Policy Termination Date: \_\_\_\_\_  
\_\_\_\_\_ Other: Please explain in the space provided below

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Contact Name: \_\_\_\_\_ Contact Telephone #: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

DMS Approved: January 10, 2011

## 5.5 Provider Inquiry Form

Provider Inquiry Forms may be used for any unique questions concerning claim status; paid or denied claims; and billing concerns. The mailing address for the Provider Inquiry Form is:

DXC Technology  
Provider Services  
P.O. Box 2100  
Frankfort, KY 40602-2100

Please keep the following points in mind when using this form:

- Send the completed form to DXC Technology. A copy is returned with a response;
- When resubmitting a corrected claim, do not attach a Provider Inquiry Form;
- A toll free DXC Technology number **1-800-807-1232** is available in lieu of using this form; and,
- To check claim status, call the DXC Technology Voice Response on **1-800-807-1301** or you may use the KY HealthNet by logging into <https://home.kymmis.com>.

### Provider Inquiry Form

DXC Technology  
P.O. Box 2100  
Frankfort, KY 40602

Please check claim status, verify eligibility, and download Remittance statements using KY HealthNet. Please contact the EDI Helpdesk at (800) 205-4696 for access information.

Provider Number	Member Name
Provider Name/Address	Member ID Number
Billed Amount	Claim Service Date/(ICN if applicable)

Providers Message

\_\_\_\_\_  
Signature/Date

#### DXC TECHNOLOGY RESPONSE:

	This claim was previously processed according to KY Medicaid guidelines. Claim will be sent for denial.
	This claim has been sent to processing.
	AGED CLAIM, claim will be sent for denial. See reverse side for timely filing guidelines.

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature/Date

\*HIPAA Privacy Notification: This message and accompanying documents are covered by the Communications Privacy Act, 18 U.S.C. 2510-2521, and contain information for the specified individual only. This information is confidential. If you are not the intended recipient, you are hereby notified that you have received this document in error and that any review, dissemination, copying, or the taking of any action based on the contents of this information is strictly prohibited. If you have received this communication in error please notify us immediately and delete the original message.

## 5.6 Prior Authorization Information

- The prior authorization process does NOT verify anything except medical necessity. It does not verify eligibility or age.
- The prior authorization letter does not guarantee payment. It only indicates that the service is approved based on medical necessity.
- If the individual does not become eligible for Kentucky Medicaid, loses Kentucky Medicaid eligibility, or ages out of the program eligibility, services will not be reimbursed despite having been deemed medically necessary.
- Prior Authorization should be requested prior to the provision of services except in cases of:
  - Retro-active Member eligibility
  - Retro-active provider number
- Providers should always completely review the Prior Authorization Letter prior to providing services or billing.

Access the KY HealthNet website to obtain blank Prior Authorization forms.

<http://www.kymmis.com/kymmis/Provider%20Relations/PriorAuthorizationForms.aspx>

Access to Electronic Prior Authorization request (EPA).

<https://home.kymmis.com>

## 5.7 Adjustments and Claim Credit Requests

An adjustment is a change to be made to a “PAID” claim. The mailing address for the Adjustment Request form is:

DXC Technology  
P.O. Box 2108  
Frankfort, KY 40602-2108  
Attn: Financial Services

Please keep the following points in mind when filing an adjustment request:

- Attach a copy of the corrected claim and the paid remittance advice page to the adjustment form. For a Medicaid/Medicare crossover, attach an EOMB (Explanation of Medicare Benefits) to the claim;
- Do not send refunds on claims for which an adjustment has been filed;
- Be specific. Explain exactly what is to be changed on the claim;
- Claims showing paid zero dollar amounts are considered paid claims by Medicaid. If the paid amount of zero is incorrect, the claim requires an adjustment; and,
- An adjustment is a change to a paid claim; a claim credit simply voids the claim entirely.



### Provider Inquiry Form

DXC Technology  
P.O. Box 2100  
Frankfort, KY 40602

Please check claim status, verify eligibility, and download Remittance statements using KY HealthNet. Please contact the EDI Helpdesk at (800) 205-4696 for access information.

Provider Number	Member Name
Provider Name/Address	Member ID Number
Billed Amount	Claim Service Date/(ICN if applicable)

Providers Message

\_\_\_\_\_  
Signature/Date

#### DXC TECHNOLOGY RESPONSE:

	This claim was previously processed according to KY Medicaid guidelines. Claim will be sent for denial.
	This claim has been sent to processing.
	AGED CLAIM, claim will be sent for denial. See reverse side for timely filing guidelines.

Other: \_\_\_\_\_

\_\_\_\_\_  
Signature/Date

\*HIPAA Privacy Notification: This message and accompanying documents are covered by the Communications Privacy Act, 18 U.S.C. 2510-2521, and contain information for the specified individual only. This information is confidential. If you are not the intended recipient, you are hereby notified that you have received this document in error and that any review, dissemination, copying, or the taking of any action based on the contents of this information is strictly prohibited. If you have received this communication in error please notify us immediately and delete the original message.

## **5.8 Cash Refund Documentation Form**

The Cash Refund Documentation Form is used when refunding money to Medicaid. The mailing address for the Cash Refund Form is:

DXC Technology  
P.O. Box 2108  
Frankfort, KY 40602-2108  
Attn: Financial Services

Please keep the following points in mind when refunding:

- Attach the Cash Refund Documentation Form to a check made payable to the KY State Treasurer.
- Attach applicable documentation, such as a copy of the remittance advice showing the claim for which a refund is being issued.
- If refunding all claims on an RA, the check amount must match the total payment amount on the RA. If refunding multiple RAs, a separate check must be issued for each RA.

**DXC Technology**

Mail To: DXC Technology  
P.O. Box 2108  
Frankfort, KY 40602-2108  
ATTN: Financial Services

## CASH REFUND DOCUMENTATION

1. Check Number		2. Check Amount	
3. Provider Name/ID/Address		4. Member Name	
		5. Member Number	
6. From Date of Service	7. To Date of Service	8. RA Date	
9. Internal Control Number (If server ICNs, attach RAs)			

**Research for Refund: (Check appropriate blank)**

- \_\_\_\_\_ a. Payment from other source – Check the category and list name (*attach copy of EOB*)
- \_\_\_\_\_ Health Insurance
- \_\_\_\_\_ Auto Insurance
- \_\_\_\_\_ Medicare Paid
- \_\_\_\_\_ Other
- \_\_\_\_\_ b. Billed in error
- \_\_\_\_\_ c. Duplicate payment (attach a copy of both RAs)
- If RAs are paid to two different providers, specify to which provider ID the check is to be applied.*
- \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_
- \_\_\_\_\_ d. Processing error OR overpayment (explain why)
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_ e. Paid to wrong provider
- \_\_\_\_\_ f. Money has been requested – date of the letter \_\_\_\_\_ | \_\_\_\_\_
- (attach a copy of letter requesting money)
- \_\_\_\_\_ g. Other \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Contact Name	Phone
--------------	-------

DMS Approved: January 10, 2011

## **5.9 Return to Provider Letter**

Claims and attached documentation received by DXC Technology are screened for required information (listed below). If the required information is not complete, the claim is returned to the provider with a “Return to Provider Letter” attached explaining why the claim is being returned.

A claim is returned before processing if the following information is missing:

- Provider ID;
- Member Identification number;
- Member first and last names; and,
- EOMB for Medicare/Medicaid crossover claims.

Other reasons for return may include:

- Illegible claim date of service or other pertinent data;
- Claim lines completed exceed the limit; and,
- Unable to image.

DXC

**RETURN TO PROVIDER LETTER**

Date: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Dear Provider,

The attached claim is being returned for the following reason(s). These items require correction before the claim can be processed.

- 01) \_\_\_\_\_ PROVIDER NUMBER – A valid NPI or provider number must be on the claim form in the appropriate field.  
       \_\_\_\_\_ Missing \_\_\_\_\_ Not a valid provider number
- 02) \_\_\_\_\_ PROVIDER SIGNATURE – All claims require an original signature in the provider signature block. The Provider signature cannot be stamped or typed on the claim.  
       \_\_\_\_\_ Missing  
       \_\_\_\_\_ Typed signature not valid  
       \_\_\_\_\_ Stamped signature not valid
- 03) \_\_\_\_\_ Detail lines exceed the limit for claim type.
- 04) \_\_\_\_\_ UNABLE TO IMAGE OR KEY – Claim form/EOMB must be legible. Highlighted forms cannot be accepted. Please resubmit on a new form.  
       \_\_\_\_\_ Print too light \_\_\_\_\_ Print too dark \_\_\_\_\_ Highlighted data fields \_\_\_\_\_ Not legible \_\_\_\_\_ Dark copy
- 05) \_\_\_\_\_ Medicaid **does not** make payment when Medicare has paid the amount in full.
- 06) \_\_\_\_\_ The Recipient's Medicaid (MAID) number is missing.
- 07) \_\_\_\_\_ Medicare Coding Sheet does not match the claim  
       \_\_\_\_\_ Dates of Service \_\_\_\_\_ Member Number \_\_\_\_\_ Charges \_\_\_\_\_ Balance due in Block 30
- 08) \_\_\_\_\_ Other Reason

\_\_\_\_\_ **Claims are being returned to you for correction for the reasons noted above.**

<b>Helpful Hints When Billing for Services Provided to a Medicaid Member</b>
--

- The Member's Medicaid number on the CMS 1500 (08/05) must be entered Field 9A
- The Member's Medicaid number on the CMS 1500 (02/12) must be entered Field 1A
- The Member's Medicaid number on the UB04 must be entered Block 60
- Medicare numbers **are not** valid Medicaid numbers
- Please refer to your billing manual if you have any concerns about billing the Medicaid program correctly.

Please make the necessary corrections and resubmit for processing. If you have any questions, please feel free to contact our Provider Relations Group, open Monday through Friday, 8:00 a.m. until 6:00 p.m. eastern standard/daylight savings time, at 1-800-807-1232.

If you are interested in billing Medicaid electronically, please contact DXC Technology at 1-800-205-4696 7:30 a.m. to 6 p.m. Monday through Friday except holidays.

Initials of Clerk \_\_\_\_\_

Provider Name \_\_\_\_\_

Provider Number \_\_\_\_\_

Reason Code \_\_\_\_\_

## 5.10 Provider Representative List

### 5.10.1 Phone Numbers and Assigned Counties

<b>Martha Edwards</b> <b>502-209-3100</b> <b>Extension 2111045</b> <b>Martha.senn@dxs.com</b>			<b>Vicky Hicks</b> <b>502-209-3100</b> <b>Extension 2111016</b> <b>vicky.hicks@dxs.com</b>		
<b>Assigned Counties</b>			<b>Assigned Counties</b>		
ADAIR	GREEN	MCCREARY	ANDERSON	GARRARD	MENIFEE
ALLEN	HART	MCLEAN	BATH	GRANT	MERCER
BALLARD	HARLAN	METCALFE	BOONE	GRAYSON	MONTGOMERY
BARREN	HENDERSON	MONROE	BOURBON	GREENUP	MORGAN
BELL	HICKMAN	MUHLENBERG	BOYD	HANCOCK	NELSON
BOYLE	HOPKINS	OWSLEY	BRACKEN	HARDIN	NICHOLAS
BREATHITT	JACKSON	PERRY	BRECKINRIDGE	HARRISON	OHIO
CALDWELL	KNOX	PIKE	BULLITT	HENRY	OLDHAM
CALLOWAY	KNOTT	PULASKI	BUTLER	JEFFERSON	OWEN
CARLISLE	LARUE	ROCKCASTLE	CAMPBELL	JESSAMINE	PENDLETON
CASEY	LAUREL	RUSSELL	CARROLL	JOHNSON	POWELL
CHRISTIAN	LESLIE	SIMPSON	CARTER	KENTON	ROBERTSON
CLAY	LETCHER	TAYLOR	CLARK	LAWRENCE	ROWAN
CLINTON	LINCOLN	TODD	DAVIESS	LEE	SCOTT
CRITTENDEN	LIVINGSTON	TRIGG	ELLIOTT	LEWIS	SHELBY
CUMBERLAND	LOGAN	UNION	ESTILL	MADISON	SPENCER
EDMONSON	LYON	WARREN	FAYETTE	MAGOFFIN	TRIMBLE
FLOYD	MARION	WAYNE	FLEMING	MARTIN	WASHINGTON
FULTON	MARSHALL	WEBSTER	FRANKLIN	MASON	WOLFE
GRAVES	MCCRACKEN	WHITLEY	GALLATIN	MEADE	WOODFORD

- **NOTE – Out-of-state providers contact the Representative who has the county closest bordering their state, unless noted above.**
- **Provider Relations contact number: 1-800-807-1232**

---

## 6 Completion of CMS-1500 Paper Claim form

The CMS-1500 claim form is used to bill services for Title V Services provided by The Department for Community Based Services. A copy of a completed claim form is shown on the following page.

Providers may order paper CMS-1500 claim forms from the:

U.S. Government Printing Office  
Superintendent of Documents  
P.O. Box 371954  
Pittsburgh, PA 15250-7954  
Telephone: 1-202-512-1800

**Disclaimer: The Billing Instructions Form Locator information enclosed are for the use of paper claim submission only. For Electronic claim submission information, please utilize the Companion Guides found at [www.kymmis.com](http://www.kymmis.com) under Companion Guides and EDI Guides.**

## 6.1 New CMS-1500 (02/12) Claim Form



### HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA											
<div style="display: flex; justify-content: space-between;"> <div> 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>  <small>(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#)</small> </div> <div> 1a. INSURED'S I.D. NUMBER (For Program in Item 1)  0000000000 </div> </div>											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John						3. PATIENT'S BIRTH DATE MM DD YY 12 01 2001			4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
5. PATIENT'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code)		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) IF OTHER INSURANCE MAKES PAYMENT						10. IS PATIENT'S CONDITION RELATED TO: IF APPLICABLE			11. INSURED'S POLICY GROUP OR FECA NUMBER		
a. OTHER INSURED'S POLICY OR GROUP NUMBER IF OTHER INSURANCE MAKES PAYMENT						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC)		
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME		
d. INSURANCE PLAN NAME OR PROGRAM NAME IF OTHER INSURANCE MAKES PAYMENT						10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>		
<p style="text-align: center;"><b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b></p> 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____											
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL						15. OTHER DATE QUAL MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						17b. NPI			20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. 12345 B. C. D. E. F. G. H. I. J. K. L.						ICD Ind. 9			22. RESUBMISSION CODE ORIGINAL REF. NO.		
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD-9-CM I. ID. QUAL J. RENDERING PROVIDER ID. #						23. PRIOR AUTHORIZATION NUMBER IF APPLICABLE					
1 05 24 13 99 H2021 HM A \$50 00 1 NPI 23000000						2					
3						3					
4						4					
5						5					
6						6					
25. FEDERAL TAX I.D. NUMBER SSN EIN						26. PATIENT'S ACCOUNT NO. 14 DIGITS			27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED <i>Ralph Smidlap</i> DATE 10/01/13						32. SERVICE FACILITY LOCATION INFORMATION If Applicable			33. BILLING PROVIDER INFO & PH # ( ) Your Place 100 Broadway Anytown, KY 40000		
28. TOTAL CHARGE \$ \$50 00						29. AMOUNT PAID \$ IF APPLICABLE			30. Rsvd for NUCC Use		

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)



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## 6.2 Completion of New CMS-1500 (02/12) Paper Claim Form

### 6.2.1 Detailed Instructions

Claims are returned or rejected if required information is incorrect or omitted. Handwritten claims must be completed in black ink ONLY.

The following fields must be completed:

FIELD NUMBER	FIELD NAME AND DESCRIPTION
<b>1A</b>	<b>Insured's I.D. Number</b>
	Enter the 10 digit Member Identification number exactly as it appears on the current Member Identification card.
<b>2</b>	<b>Patient's Name</b>
	Enter the Member's last name, first name and middle initial exactly as it appears on the Member Identification card.
<b>3</b>	<b>Date of Birth</b>
	Enter the member's date of birth.
<b>9</b>	<b>Other Insured's Name</b>
	Enter the Insured's Name. Required only if member is covered by insurance other than Medicaid or Medicare and the other insurance has made a payment on the claim.
<b>9A</b>	<b>Other Insured's Policy Group Number</b>
	Required only if member is covered by insurance other than Medicaid or Medicare and the other insurance has made a payment on the claim. If this field is completed, also complete Fields 9D and 29.  NOTE: If other insurance denies the submitted claim, leave Fields 9, 9A, 9D and 29 blank and attach denial statement from other insurance carrier to the CMS-1500 (02/12) claim.
<b>9D</b>	<b>Insurance Plan or Program Name</b>
	Enter the Member's insurance carrier name. Complete only if entry in 9.
<b>10</b>	<b>Patient's Condition</b>
	Required if Member's condition is related to employment, auto accident, or other accident. Check the appropriate block if Member's condition relates to any of the above.

<b>17</b>	<b>Name of Referring Provider or Other Source</b>
	Enter the qualifier and the name of the Referring Provider or Ordering Provider, if applicable.  <b>Qualifiers:</b>  DN – Denotes Referring Provider DK – Denotes Ordering Provider
<b>17B</b>	<b>Name of Referring Provider or Other Source</b>
	Enter the Referring or Ordering Provider NPI, if applicable.
<b>21</b>	<b>Diagnosis or Nature of Illness of Injury</b>
	Enter an ICD indicator in the upper right corner to indicate the type of diagnosis being used.  9= ICD-9 0= ICD-10  Twelve diagnosis codes may be entered.
<b>23</b>	<b>Prior Authorization</b>
	Enter the 10 digit prior authorization number, if applicable.  <b>NOTE: See section 4.6 Prior Authorization for details.</b>
<b>24A</b>	<b>Date of Service (Non-Shaded Area)</b>
	Enter the date in month, day, year format (MMDDYY).
<b>24B</b>	<b>Place of Service (Non-Shaded Area)</b>
	Enter a valid two digit place of service. <b>*See Appendix G</b>
<b>24D</b>	<b>Procedure Code (Non-Shaded Area)</b>
	Enter the appropriate HIPAA compliant procedure code identifying the service or supply provided to the Member.  <b>NOTE: See Appendix F for a list of the procedure codes and modifiers.</b>
	<b>Modifier (Non-Shaded Area)</b>
	Enter the appropriate two digit modifier, if applicable.
<b>24E</b>	<b>Diagnosis Code Indicator (Non-Shaded Area)</b>
	Enter the diagnosis pointers A-L to refer to a diagnosis code in field 21. Do not enter the actual ICD-10 diagnosis code.

<b>24F</b>	<b>Charges (Non-Shaded Area)</b>
	Enter the usual and customary charge for the service being provided to the Member.
<b>24G</b>	<b>Days or Units (Non-Shaded Area)</b>
	Enter the appropriate units of service.
<b>24I</b>	<b>ID Qualifier (Shaded Area)</b>
	Enter a G2 to indicate Medicaid Provider.
<b>24J</b>	<b>Rendering Provider ID# (Shaded Area)</b>
	Enter the eight digit KY Medicaid rendering provider ID 23 _ _ _ _ _ .
<b>26</b>	<b>Patient's Account No.</b>
	There must be an entry in this field.
<b>28</b>	<b>Total Charges</b>
	Enter the total of all individual charges entered in Field 24F. Total each claim separately.
<b>31</b>	<b>Date</b>
	Enter the date in numeric format (MMDDYY). This date must be on or after the date(s) of service on the claim.
<b>33</b>	<b>Physician/ Supplier's Billing Name, Address, Zip Code and Phone Number</b>
	Enter the provider's name, address, zip code and phone number (including area code).
<b>33B</b>	<b>(Shaded Area)</b>
	Enter G2 plus the eight digit group provider number.

### 6.3 Instructions for Completion of Field 26

- If you are billing procedures H2021, 90804, 90853, 90887, T1023 and/or H2019, you must enter your tax ID in field 26 as the patient account number, which become the invoice number.
- If you are billing procedure codes 99244 or 99245, you must make an entry, which includes an alphanumeric combination, which includes CATS and the date of transmission

- 
- Example: For claims transmitted on January 1, 2003, the entry in field 26 is CATS01012003 for all claims transmitted that day.
  - If you are billing procedure codes, T2023, 99199, T1025 or H0043 you must make an entry which includes an alpha numeric combination which includes either JJMA and the date of transmission or TWIST and the date of transmission.
  - Example: For claims transmitted by the Department for Juvenile Justice (DJJ) on January 1, 2003, the entry in field 26 is JJMA01012003 for all claims transmitted that day. For claims transmitted by the Cabinet for Families and Children (CFC) on January 1, 2006, the entry in field 26 is TWIST01012006 for all claims transmitted that day.

---

## 6.4 Helpful Hints for Successful CMS-1500 (02/12) Filing

- Any required documentation for claims processing must be attached to each claim. Each claim is processed separately.
- Be sure to include the “AS OF” date and “EOB” code when copying a remittance advice as proof of timely filing or for inquiries concerning claim status.
- Please follow up on a claim that appears to be outstanding after four weeks from your submission date.
- Field 24B (Place of Service) requires a two digit code.
- Field 24E (Diagnosis Code Indicator) is a one digit only field.
- If any insurance other than Medicare/KY Medicaid makes a payment on services you are billing, complete Fields 9, 9A, 9D, and 29 on the CMS-1500 (02/12) claim form.
- If insurance does not make a payment on services you are billing, attach the private insurance denial to the CMS-1500 claim form. Do not complete Fields 9, 9A, 9D, and 29 on the CMS-1500 (02/12) claim form.
- When billing the same procedure code, for the same date of service, you must bill on one line indicating the appropriate units of service.
- Do NOT check blocks for Medicare or KY Medicaid on the top of the CMS-1500 (08/05) claim form.
- When submitting claims for the coinsurance and/or deductible after Medicare payment, do not cut your EOMB into strips. The Medicare paid date on the EOMB must be visible and is required for processing.
- If you are submitting a copy of a previously submitted claim on which some line items have paid and some denied, mark through or delete any line(s) on the claim already paid. If you mark through any lines, be sure to recompute your total charge in Field 28 to reflect the new total charge billed.

## 6.5 Mailing Information

Send the CMS-1500 claim form to DXC Technology for processing as soon as possible after the service is rendered. Retain a copy in the office file.

Mail completed claims to:  
DXC Technology  
P.O. Box 2101  
Frankfort, KY 40602-2101

---

## 7 Appendix A

### 7.1 Internal Control Number (ICN)

An Internal Control Number (ICN) is assigned by DXC Technology to each claim. During the imaging process a unique control number is assigned to each individual claim for identification, efficient retrieval, and tracking. The ICN consists of 13 digits and contains the following information:

**11 – 10 – 032 - 123456**

**1      2      3      4**

1. Region

<b>10</b>	PAPER CLAIMS WITH NO ATTACHMENTS
<b>11</b>	PAPER CLAIMS WITH ATTACHMENTS
<b>20</b>	ELECTRONIC CLAIMS WITH NO ATTACHMENTS
<b>21</b>	ELECTRONIC CLAIMS WITH ATTACHMENTS
<b>22</b>	INTERNET CLAIMS WITH NO ATTACHMENTS
<b>40</b>	CLAIMS CONVERTED FROM OLD MMIS
<b>45</b>	ADJUSTMENTS CONVERTED FROM OLD MMIS
<b>50</b>	ADJUSTMENTS - NON-CHECK RELATED
<b>51</b>	ADJUSTMENTS - CHECK RELATED
<b>52</b>	MASS ADJUSTMENTS - NON-CHECK RELATED
<b>53</b>	MASS ADJUSTMENTS - CHECK RELATED
<b>54</b>	MASS ADJUSTMENTS - VOID TRANSACTION
<b>55</b>	MASS ADJUSTMENTS - PROVIDER RATES
<b>56</b>	ADJUSTMENTS - VOID NON-CHECK RELATED
<b>57</b>	ADJUSTMENTS - VOID CHECK RELATED

2. Year of Receipt

3. Julian Date of Receipt (The Julian calendar numbers the days of the year 1-365. For example, 001 is January 1 and 032 (shown above) is February 1.

4. Batch Sequence Used Internally

---

## 8 Appendix B

### 8.1 Remittance Advice

This section is a step-by-step guide to reading a Kentucky Medicaid Remittance Advice (RA). The following sections describe major categories related to processing/adjudicating claims. To enhance this document's usability, detailed descriptions of the fields on each page are included, reading the data from left to right, top to bottom.

#### 8.1.1 Examples of Pages in Remittance Advice

There are several types of pages in a Remittance Advice, including separate page types for each type of claim; however, if a provider does not have activity in that particular category, those pages are not included.

Following are examples of pages which may appear in a Remittance Advice:

FIELD	DESCRIPTION
<b>Returned Claims</b>	This section lists all claims that have been returned to the provider with an RTP letter. The RTP letter explains why the claim is being returned. These claims are returned because they are missing information required for processing.
<b>Paid Claims</b>	This section lists all claims paid in the cycle.
<b>Denied Claims</b>	This section lists all claims that denied in the cycle.
<b>Claims In Process</b>	This section lists all claims that have been suspended as of the current cycle. The provider should maintain this page and compare with future Remittance Advices until all the claims listed have appeared on the PAID CLAIMS page or the DENIED CLAIMS page. Until that time, the provider need not resubmit the claims listed in this section.
<b>Adjusted Claims</b>	This section lists all claims that have been submitted and processed for adjustment or claim credit transactions.
<b>Mass Adjusted Claims</b>	This section lists all claims that have been mass adjusted at the request of the Department for Medicaid Services (DMS).
<b>Financial Transactions</b>	This section lists financial transactions with activity during the week of the payment cycle.
	<b>NOTE: It is imperative the provider maintains any A/R page with an outstanding balance.</b>

---

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<b>Summary</b>	This section details all categories contained in the Remittance Advice for the current cycle, month to date, and year to date. Explanation of Benefit (EOB) codes listed throughout the Remittance Advice is defined in this section.
<b>EOB Code Descriptions</b>	Any Explanation of Benefit Codes (EOB) which appears in the RA is defined in this section.

**NOTE:** For the purposes of reconciliation of claims payments and claims resubmission of denied claims, it is highly recommended that all remittance advices be kept for at least one year.



---

## 8.2 Title

The header information that follows is contained on every page of the Remittance Advice.

REPORT: CRA-XBPD-R  
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE

DATE: 01/25/2007  
PAGE: 2

FIELD	DESCRIPTION
DATE	The date the Remittance Advice was printed.
RA NUMBER	A system generated number for the Remittance Advice.
PAGE	The number of the page within each Remittance Advice.
CLAIM TYPE	The type of claims listed on the Remittance Advice.
PROVIDER NAME	The name of the provider that billed. (The type of provider is listed directly below the name of provider.)
PAYEE ID	The eight-digit Medicaid assigned provider ID of the billing provider.
NPI ID	The NPI number of the billing provider.

The category (type of page) begins each section and is centered (for example, \*PAID CLAIMS\*). All claims contained in each Remittance Advice are listed in numerical order of the prescription number.

## 8.3 Banner Page

All Remittance Advices have a “banner page” as the first page. The “banner page” contains provider specific information regarding upcoming meetings and workshops, “top ten” billing errors, policy updates, billing changes etc. Please pay close attention to this page.

REPORT: CRA-BANN-R  
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE  
PROVIDER BANNER MESSAGES

DATE: 01/23/2007  
PAGE: 1

PROVIDER  
555 ANY STREET  
CITY, KY 55555-0000

PAYEE ID 99999999  
NPI ID 99999999  
CHECK/EFT NUMBER 99999999  
ISSUE DATE 01/26/2007

Commonwealth of Kentucky

REPORT: CRA-BANN-R  
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE  
CMS 1500 CLAIMS PAID

DATE: 01/23/2007  
PAGE: 1

PROVIDER  
555 ANY STREET  
CITY, KY 55555-0000

PAYEE ID 99999999  
NPI ID  
CHECK/EFT NUMBER 999999999  
ISSUE DATE 01/26/2007

--ICN--	SERVICE DATES	BILLED	ALLOWED	TPL	SPENDDOWN	CO-PAY	PAID																														
--PATIENT NUMBER--	FROM THRU	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT																														
MEMBER NAME: JANE DOE MEMBER NO.: 9999999999																																					
999999999999	060606 060606	200.00		0.00			0.00																														
99999999XXX			18.05		0.00	2.00	16.05																														
<table border="1"> <thead> <tr> <th>PL SERV</th> <th>PROC CD</th> <th>MODIFIERS</th> <th>UNITS</th> <th>SERVICE DATES</th> <th>RENDERING</th> <th>BILLED</th> <th>ALLOWED</th> <th>DETAIL</th> <th>EOBS</th> </tr> <tr> <th></th> <th></th> <th></th> <th></th> <th>FROM THRU</th> <th>PROVIDER</th> <th>AMOUNT</th> <th>AMOUNT</th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td>22</td> <td>88304</td> <td>TC</td> <td>1.00</td> <td>060606 060606</td> <td>MCD 64000000</td> <td>200.00</td> <td>18.05</td> <td>5001 0018 9918</td> <td>00A2</td> </tr> </tbody> </table>								PL SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES	RENDERING	BILLED	ALLOWED	DETAIL	EOBS					FROM THRU	PROVIDER	AMOUNT	AMOUNT			22	88304	TC	1.00	060606 060606	MCD 64000000	200.00	18.05	5001 0018 9918	00A2
PL SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES	RENDERING	BILLED	ALLOWED	DETAIL	EOBS																												
				FROM THRU	PROVIDER	AMOUNT	AMOUNT																														
22	88304	TC	1.00	060606 060606	MCD 64000000	200.00	18.05	5001 0018 9918	00A2																												
TOTAL CMS 1500 CLAIMS PAID: 200.00																																					
			18.05		0.00		0.00	16.05																													

## 8.4 Paid Claims Page

FIELD	DESCRIPTION
<b>PATIENT ACCOUNT</b>	The 14-digit alpha/numeric Patient Account Number from Form Locator 3.
<b>MEMBER NAME</b>	The Member's last name and first initial.
<b>MEMBER NUMBER</b>	The Member's ten-digit Identification number as it appears on the Member's Identification card.
<b>ICN</b>	The 12-digit unique system generated identification number assigned to each claim by DXC Technology.
<b>CLAIM SERVICE DATES FROM – THRU</b>	The date or dates the service was provided in month, day, and year numeric format.
<b>BILLED AMOUNT</b>	The usual and customary charge for services provided for the Member.
<b>ALLOWED AMOUNT</b>	The allowed amount for Medicaid
<b>TPL AMOUNT</b>	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
<b>SPENDDOWN AMOUNT</b>	The amount collected from the member.
<b>COPAY AMOUNT</b>	The amount collected from the member.
<b>PAID AMOUNT</b>	The total dollar amount reimbursed by Medicaid for the claim listed.
<b>EOB</b>	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.
<b>CLAIMS PAID ON THIS RA</b>	The total number of paid claims on the Remittance Advice.
<b>TOTAL BILLED</b>	The total dollar amount billed by the provider for all claims listed on the PAID CLAIMS page of the Remittance Advice (only on final page of section).
<b>TOTAL PAID</b>	The total dollar amount paid by Medicaid for all claims listed on the PAID CLAIMS page of the Remittance Advice (only on final page of section).



### 8.5 Denied Claims Page

<b>FIELD</b>	<b>DESCRIPTION</b>
<b>PATIENT ACCOUNT</b>	The 14-digit alpha/numeric Patient Control Number from Form Locator 3.
<b>MEMBER NAME</b>	The Member's last name and first initial.
<b>MEMBER NUMBER</b>	The Member's ten-digit Identification number as it appears on the Member's Identification card.
<b>ICN</b>	The 12-digit unique system generated identification number assigned to each claim by DXC Technology.
<b>CLAIM SERVICE DATE FROM – THRU</b>	The date or dates the service was provided in month, day, and year numeric format.
<b>BILLED AMOUNT</b>	The usual and customary charge for services provided for the Member.
<b>TPL AMOUNT</b>	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
<b>SPENDDOWN AMOUNT</b>	The amount owed from the member.
<b>EOB</b>	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.
<b>CLAIMS DENIED ON THIS RA</b>	The total number of denied claims on the Remittance Advice.
<b>TOTAL BILLED</b>	The total dollar amount billed by the Home Health Services for all claims listed on the DENIED CLAIMS page of the Remittance Advice (only on final page of section).

REPORT: CRA-BANN-R  
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE  
CMS 1500 CLAIMS IN PROCESS

DATE: 01/23/2007  
PAGE: 1

PROVIDER  
555 ANY STREET  
CITY, KY 55555-0000

PAYEE ID 99999999  
NPI ID  
CHECK/EFT NUMBER 99999999  
ISSUE DATE 01/26/2007

--ICN--	SERVICE DATES	BILLED	TPL
--PATIENT NUMBER--	FROM THRU	AMOUNT	AMOUNT
MEMBER NAME: JANE DOE	MEMBER NO.: 9999999999		
999999999999	060606 060606	200.00	0.00
99999999XXX			

PL SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES	RENDERING	BILLED	DETAIL EOB
				FROM THRU	PROVIDER	AMOUNT	
22	88304	TC	1.00	060606 060606	MCD 64000000	200.00	

TOTAL CMS 1500 CLAIMS IN PROCESS: 200.00 0.00

## 8.6 Claims in Process Page

<b>FIELD</b>	<b>DESCRIPTION</b>
<b>PATIENT ACCOUNT</b>	The 14-digit alpha/numeric Patient Control Number from Form Locator 3.
<b>MEMBER NAME</b>	The Member's last name and first initial.
<b>MEMBER NUMBER</b>	The Member's ten-digit Identification number as it appears on the Member's Identification card.
<b>ICN</b>	The 13-digit unique system-generated identification number assigned to each claim by DXC Technology.
<b>CLAIM SERVICE DATE FROM – THRU</b>	The date or dates the service was provided in month, day, and year numeric format.
<b>BILLED AMOUNT</b>	The usual and customary charge for services provided for the Member.
<b>TPL AMOUNT</b>	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
<b>EOB</b>	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.



REPORT: CRA-IPPD-R  
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE  
CMS CLAIMS RETURNED

DATE: 01/30/2007  
PAGE: 2

PROVIDER  
5555 ANY STREET  
CITY, KY 55555-5555

PAYEE ID 99999999  
NPI ID  
CHECK/EFT NUMBER 99999999  
ISSUE DATE 02/02/2007

--ICN-- REASON CODE  
999999999999 01

CLAIMS RETURNED: 01

**8.7 Returned Claim**

<b>FIELD</b>	<b>DESCRIPTION</b>
<b>ICN</b>	The 13-digit unique system generated identification number assigned to each claim by DXC Technology.
<b>REASON CODE</b>	A code denoting the reason for returning the claim.
<b>CLAIMS RETURNED ON THIS RA</b>	The total number of returned claims on the Remittance Advice.

**Note:** Claims appearing on the “returned claim” page are forthcoming in the mail. The actual claim is returned with a “return to provider” sheet attached, indicating the reason for the claim being returned.

REPORT: CRA-PRAD-R  
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE  
CMS CLAIM ADJUSTMENTS

DATE: 12/14/2006  
PAGE: 2

HEALTH SERVICES  
ATTN: JANE DOE  
555 ANY STREET  
CITY, KY 55555-0000

PAYEE ID 99999999  
NPI ID

--ICN--	SERVICE DATES		BILLED	ALLOWED	TPL	SPENDDOWN	CO-PAY	PAID																																				
--PATIENT NUMBER--	FROM	THRU	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT																																				
MEMBER NAME: JANE DOE MEMBER NO.: 9999999999																																												
99999999999999	031103	031103	(20.00)		(0.00)		(0.00)																																					
99999				(20.00)		(0.00)		(20.00)																																				
99999999999999	031103	031103	20.00		0.00		0.00																																					
99999				20.00		0.00		20.00																																				
<table border="1"> <thead> <tr> <th>PL SERV</th> <th>PROC CD</th> <th>MODIFIERS</th> <th>UNITS</th> <th colspan="3">SERVICE DATES RENDERING</th> <th>PROVIDER</th> <th>BILLED</th> <th>ALLOWED</th> <th>DETAIL</th> <th>EOBS</th> </tr> <tr> <th></th> <th></th> <th></th> <th></th> <th>FROM</th> <th>THRU</th> <th></th> <th></th> <th>AMOUNT</th> <th>AMOUNT</th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td>99</td> <td>WP101</td> <td></td> <td>1.00</td> <td>031103</td> <td>031103</td> <td>MCD 40097065</td> <td></td> <td>20.00</td> <td>20.00</td> <td>0102</td> <td>0029</td> </tr> </tbody> </table>									PL SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES RENDERING			PROVIDER	BILLED	ALLOWED	DETAIL	EOBS					FROM	THRU			AMOUNT	AMOUNT			99	WP101		1.00	031103	031103	MCD 40097065		20.00	20.00	0102	0029
PL SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES RENDERING			PROVIDER	BILLED	ALLOWED	DETAIL	EOBS																																	
				FROM	THRU			AMOUNT	AMOUNT																																			
99	WP101		1.00	031103	031103	MCD 40097065		20.00	20.00	0102	0029																																	
TOTAL NO. OF ADJ: 1																																												
TOTAL CMS 1500 ADJUSTMENT CLAIMS:																																												
				0.00				0.00	0.00																																			
								0.00	0.00		0.00																																	

Providers have an option of requesting an adjustment, as indicated above; or requesting a cash refund (form and instructions for completion can be found in the Billing Instructions).

If a cash refund is submitted, an adjustment **CANNOT** be filed.  
If an adjustment is submitted, a cash refund **CANNOT** be filed.

## 8.8 Adjusted Claims Page

The information on this page reads left to right and does not follow the general headings.

FIELD	DESCRIPTION
<b>PATIENT ACCOUNT</b>	The 14-digit alpha/numeric Patient Control Number from Form Locator 3.
<b>MEMBER NAME</b>	The Member's last name and first initial.
<b>MEMBER NUMBER</b>	The Member's ten-digit Identification number as it appears on the Member's Identification card.
<b>ICN</b>	The 12-digit unique system generated identification number assigned to each claim by DXC Technology.
<b>CLAIM SERVICE DATES FROM – THRU</b>	The date or dates the service was provided in month, day, and year numeric format.
<b>BILLED AMOUNT</b>	The usual and customary charge for services provided for the Member.
<b>ALLOWED AMOUNT</b>	The amount allowed for this service.
<b>TPL AMOUNT</b>	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
<b>COPAY AMOUNT</b>	Copay amount to be collected from member.
<b>SPENDDOWN AMOUNT</b>	The amount to be collected from the member.
<b>PAID AMOUNT</b>	The total dollar amount reimbursed by Medicaid for the claim listed.
<b>EOB</b>	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.
<b>PAID AMOUNT</b>	Amount paid.

**Note:** The ORIGINAL claim information appears first, followed by the NEW (adjusted) claim information.

REPORT: CRA-TRAN-R  
RA#: 9999999

COMMONWEALTH OF KENTUCKY  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE  
FINANCIAL TRANSACTIONS

DATE: 12/26/2006  
PAGE: 2

PROVIDER J  
PO BOX 5555  
CITY, KY 55555-5555

PAYEE ID 99999999  
NPI ID 99999999

-----NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS-----

TRANSACTION	PAYOUT	REASON	RENDERING	SVC DATE				
NUMBER	--CCN--	--AMOUNT--	CODE	PROVIDER	FROM	THRU	MEMBER NO.	MEMBER NAME

NO NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS

-----NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS-----

	REFUND	REASON		
--CCN--	--AMOUNT--	CODE	MEMBER NO.	MEMBER NAME

NO NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS

-----ACCOUNTS RECEIVABLE-----

A/R	SETUP	RECOUPED	ORIGINAL	TOTAL	REASON	
NUMBER/ICN	DATE	THIS CYCLE	AMOUNT	-RECOUPED-	--BALANCE--	CODE
1106	011306	0.00	22.41	0.00	22.41	92
TOTAL BALANCE					22.41	

## 8.9 Financial Transaction Page

### 8.9.1 Non-Claim Specific Payouts to Providers

FIELD	DESCRIPTION
TRANSACTION NUMBER	The tracking number assigned to each financial transaction.
CCN	The cash control number assigned to refund checks for tracking purposes.
PAYMENT AMOUNT	The amount paid to the provider when the financial reason code indicates money is owed to the provider.
REASON CODE	Payment reason code.
RENDERING PROVIDER	Rendering provider of service.
SERVICE DATES	The from and through dates of service.
MEMBER NUMBER	The KY Medicaid member identification number.
MEMBER NAME	The KY Medicaid member name.

### 8.9.2 Non-Claim Specific Refunds from Providers

FIELD	DESCRIPTION
CCN	The cash control tracking number assigned to refund checks for tracking purposes.
REFUND AMOUNT	The amount refunded by provider.
REASON CODE	The two byte reason code specifying the reason for the refund.
MEMBER NUMBER	The KY Medicaid member identification number.
MEMBER NAME	The KY Medicaid member name.

### 8.9.3 Accounts Receivable

FIELD	DESCRIPTION
A / R NUBMER / ICN	This is the 13-digit Internal Control Number used to identify records for one accounts receivable transaction.
SETUP DATE	The date entered on the accounts receivable transaction in the MM/DD/CCYY format. This date identifies the beginning of the accounts receivable event.

<b>RECOUPED THIS CYCLE</b>	The amount of money recouped on this financial cycle.
<b>ORIGINAL AMOUNT</b>	The original accounts receivable transaction amount owed by the provider.
<b>TOTAL RECOUPED</b>	This amount is the total of the provider's checks and recoupment amounts posted to this accounts receivable transaction.
<b>BALANCE</b>	The system generated balance remaining on the accounts receivable transaction.
<b>REASON CODE</b>	A two-byte alpha/numeric code specifying the reason an accounts receivable was processed against a providers account.

ANY RECOUPMENT ACTIVITY OR PAYMENTS RECEIVED FROM THE PROVIDER list below the "RECOUPMENT PAYMENT SCHEDULE." All initial accounts receivable allow 60 days from the "setup date" to make payment on the accounts receivable. After 60 days, if the accounts receivable has not been satisfied nor a payment plan initiated, monies are recouped from the provider on each Remittance Advice until satisfied.

**This is your only notification of an accounts receivable setup. Please keep all Accounts Receivable Summary pages until all monies have been satisfied.**

REPORT: CRA-SUMM-R  
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE  
SUMMARY

DATE: 02/01/2007  
PAGE: 13

PROVIDER  
  
P O BOX 555  
CITY, KY 55555-0000

PAYEE ID 99999999  
NPI ID  
CHECK/EFT NUMBER 999999999  
ISSUE DATE 02/02/2007

-----CLAIMS DATA-----						
	CURRENT NUMBER	CURRENT AMOUNT	MONTH-TD NUMBER	MONTH-TD AMOUNT	YEAR-TD NUMBER	YEAR-TD AMOUNT
CLAIMS PAID	43	130,784.46	43	130,784.46	1,988	4,143,010.13
CLAIM ADJUSTMENTS	0	0.00	0	0.00	18	0.00
MASS ADJUSTMENTS	0	0.00	0	0.00	0	0.00
TOTAL CLAIMS PAYMENTS	43	130,784.46	43	130,784.46	2,006	4,143,010.13
CLAIMS DENIED	1		1		917	
CLAIMS IN PROCESS	2					
-----EARNINGS DATA-----						
PAYMENTS:						
CLAIMS PAYMENTS		130,784.46		130,784.46		4,143,010.13
SYSTEM PAYOUTS (NON-CLAIM SPECIFIC)		0.00		0.00		0.00
ACCOUNTS RECEIVABLE (OFFSETS):						
CLAIM SPECIFIC:						
CURRENT CYCLE		(0.00)		(0.00)		(0.00)
OUTSTANDING FROM PREVIOUS CYCLES		(0.00)		(0.00)		(44,474.35)
NON-CLAIM SPECIFIC OFFSETS		(0.00)		(0.00)		(0.00)
NET PAYMENT		130,784.46		130,784.46		4,098,535.78
REFUNDS:						
CLAIM SPECIFIC ADJUSTMENT REFUNDS		(0.00)		(0.00)		(0.00)
NON-CLAIM SPECIFIC REFUNDS		(0.00)		(0.00)		(0.00)
OTHER FINANCIAL:						
MANUAL PAYOUTS (NON-CLAIM SPECIFIC)		0.00		0.00		0.00
VOIDS		(0.00)		(0.00)		(0.00)
NET EARNINGS		130,784.46		130,784.46		4,098,535.78



REPORT: CRA-EOBM-R  
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE  
EOB CODE DESCRIPTIONS

DATE: 02/01/2007  
PAGE: 14

PROVIDER  
  
P O BOX 555  
CITY, KY 55555-0000

PAYEE ID 99999999  
NPI ID  
CHECK/EFT NUMBER 999999999  
ISSUE DATE 02/02/2007

EOB CODE EOB CODE DESCRIPTION

0022 COVERED DAYS ARE NOT EQUAL TO ACCOMMODATION UNITS.  
0271 CLAIM DENIED. MEMBER AVAILABLE INCOME INFORMATION NOT ON FILE FOR THE MONTH OF SERVICE. PLEASE  
CONTACT DMS AT 502-564-6885.  
0409 INVALID PROVIDER TYPE BILLED ON CLAIM FORM.  
0883 CLAIM DENIED. DEPLICATE PROCEDURE HAS BEEN PAID.  
9999 PROCESSED PER MEDICAID POLICY

HIPAA REASON CODE HIPAA ADJ REASON CODE DESCRIPTION

0016 Claim/service lacks information which is needed for adjudication. Additional information is supplied  
using remittance advice remarks codes whenever appropriate  
0018 Duplicate claim/service.  
0052 The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the  
service billed.  
0092 Claim Paid in full.  
00A1 Claim denied charges.

## 8.10 Summary Page

FIELD	DESCRIPTION
<b>CLAIMS PAID</b>	The number of paid claims processed, current month and year to date.
<b>CLAIM ADJUSTMENTS</b>	The number of adjusted/credited claims processed, adjusted/credited amount billed, and adjusted/credited amount paid or recouped by Medicaid. If money is recouped, the dollar amount is followed by a negative (-) sign. These figures correspond with the summary of the last page of the ADJUSTED CLAIMS section.
<b>PAID MASS ADJ CLAIMS</b>	<p>The number of mass adjusted/credited claims, mass adjusted/credited amount billed, and mass adjusted/credited amount paid or recouped by Medicaid. These figures correspond with the summary line of the last page of the MASS ADJUSTED CLAIMS section.</p> <p>Mass Adjustments are initiated by Medicaid and DXC Technology for issues that affect a large number of claims or providers. These adjustments have their own section "MASS ADJUSTED CLAIMS" page, but are formatted the same as the ADJUSTED CLAIMS page.</p>
<b>CLAIMS DENIED</b>	These figures correspond with the summary line of the last page of the DENIED CLAIMS section.
<b>CLAIMS IN PROCESS</b>	The number of claims processed that suspended along with the amount billed of the suspended claims. These figures correspond with the summary line of the last page of the CLAIMS IN PROCESS section.

### 8.10.1 Payments

FIELD	DESCRIPTION
<b>CLAIMS PAYMENT</b>	The number of claims paid.
<b>SYSTEM PAYOUTS</b>	Any money owed to providers.
<b>NET PAYMENT</b>	Total check amount.
<b>REFUNDS</b>	Any money refunded to Medicaid by a provider.

<b>OTHER FINANCIAL</b>	
<b>NET EARNINGS</b>	The 1099 amount.

**EXPLANATION OF BENEFITS**

<b>FIELD</b>	<b>DESCRIPTION</b>
<b>EOB</b>	A five-digit number denoting the EXPLANATION OF BENEFITS detailed on the Remittance Advice.
<b>EOB CODE DESCRIPTION</b>	Description of the EOB Code. All EOB Codes detailed on the Remittance Advice are listed with a description/ definition.
<b>COUNT</b>	Total number of times an EOB Code is detailed on the Remittance Advice.

**EXPLANATION OF REMARKS**

<b>FIELD</b>	<b>DESCRIPTION</b>
<b>REMARK</b>	A five-digit number denoting the remark identified on the Remittance Advice.
<b>REMARK CODE DESCRIPTION</b>	Description of the Remark Code. All remark codes detailed on the Remittance Advice are listed with a description/definition.
<b>COUNT</b>	Total number of times a Remark Code is detailed on the Remittance Advice.

**EXPLANATION OF ADJUSTMENT CODE**

<b>FIELD</b>	<b>DESCRIPTION</b>
<b>ADJUSTMENT CODE</b>	A two-digit number denoting the reason for returning the claim.
<b>ADJUSTMENT CODE DESCRIPTION</b>	Description of the adjustment Code. All adjustment codes detailed on the Remittance Advice are listed with a description/definition.
<b>COUNT</b>	Total number of times an adjustment Code is detailed on the Remittance Advice.

**EXPLANATION OF RTP CODES**

<b>FIELD</b>	<b>DESCRIPTION</b>
<b>RTP CODE</b>	A two-digit number denoting the reason for returning the claim.
<b>RETURN CODE DESCRIPTION</b>	Description of the RTP Code. All RTP codes detailed on the Remittance Advice are listed with a description/ definition.
<b>COUNT</b>	Total number of times an RTP Code is detailed on the Remittance Advice.

## 9 Appendix C

### 9.1 Remittance Advice Location Codes (LOC CD)

The following is a code indicating the Department for Medicaid Services branch/division or other agency that originated the Accounts Receivable:

A	Active
B	Hold Recoup - Payment Plan Under Consideration
C	Hold Recoup - Other
D	Other-Inactive-FFP-Not Reclaimed
E	Other – Inactive - FFP
F	Paid in Full
H	Payout on Hold
I	Involves Interest – Cannot Be Recouped
J	Hold Recoup Refund
K	Inactive-Charge off – FFP Not Reclaimed
P	Payout – Complete
Q	Payout – Set Up In Error
S	Active - Prov End Dated
T	Active Provider A/R Transfer
U	DXC Technology On Hold
W	Hold Recoup - Further Review
X	Hold Recoup - Bankruptcy
Y	Hold Recoup - Appeal
Z	Hold Recoup - Resolution Hearing

## **10 Appendix D**

### **10.1 Remittance Advice Reason Code (ADJ RSN CD or RSN CD)**

The following is a two-byte alpha/numeric code specifying the reason an accounts receivable was processed against a provider's account:

01	Prov Refund – Health Insur Paid	32	Payout – Advance to be Recouped
02	Prov Refund – Member/Rel Paid	33	Payout – Error on Refund
03	Prov Refund – Casualty Insu Paid	34	Payout – RTP
04	Prov Refund – Paid Wrong Vender	35	Payout – Cost Settlement
05	Prov Refund – Apply to Acct Recv	36	Payout – Other
06	Prov Refund – Processing Error	37	Payout – Medicare Paid TPL
07	Prov Refund-Billing Error	38	Recoupment – Medicare Paid TPL
08	Prov Refund – Fraud	39	Recoupment – DEDCO
09	Prov Refund – Abuse	40	Provider Refund – Other TLP Rsn
10	Prov Refund – Duplicate Payment	41	Acct Recv – Patient Assessment
11	Prov Refund – Cost Settlement	42	Acct Recv – Orthodontic Fee
12	Prov Refund – Other/Unknown	43	Acct Receivable – KENPAC
13	Acct Receivable – Fraud	44	Acct Recv – Other DMS Branch
14	Acct Receivable – Abuse	45	Acct Receivable – Other
15	Acct Receivable – TPL	46	Acct Receivable – CDR-HOSP-Audit
16	Acct Recv – Cost Settlement	47	Act Rec – Demand Paymt Updt 1099
17	Acct Receivable – DXC Technology Request	48	Act Rec – Demand Paymt No 1099
18	Recoupment – Warrant Refund	49	PCG
19	Act Receivable-SURS Other	50	Recoupment – Cold Check
20	Acct Receivable – Dup Payt	51	Recoupment – Program Integrity Post Payment Review Contractor A
21	Recoupment – Fraud	52	Recoupment – Program Integrity Post Payment Review Contractor B
22	Civil Money Penalty	53	Claim Credit Balance
23	Recoupment – Health Insur TPL	54	Recoupment – Other St Branch
24	Recoupment – Casualty Insur TPL	55	Recoupment – Other
25	Recoupment – Member Paid TPL	56	Recoupment – TPL Contractor
26	Recoupment – Processing Error	57	Acct Recv – Advance Payment
27	Recoupment – Billing Error	58	Recoupment – Advance Payment
28	Recoupment – Cost Settlement	59	Non Claim Related Overage
29	Recoupment – Duplicate Payment	60	Provider Initiated Adjustment
30	Recoupment – Paid Wrong Vendor	61	Provider Initiated CLM Credit
31	Recoupment – SURS		



62	CLM CR-Paid Medicaid VS Xover	95	Beginning Recoupment Balance
63	CLM CR-Paid Xover VS Medicaid	96	Ending Recoupment Balance
64	CLM CR-Paid Inpatient VS Outp	97	Begin Dummy Rec Bal
65	CLM CR-Paid Outpatient VS Inp	98	End Dummy Recoup Balance
66	CLS Credit-Prov Number Changed	99	Drug Unit Dose Adjustment
67	TPL CLM Not Found on History	AA	PCG 2 Part A Recoveries
68	FIN CLM Not Found on History	BB	PCG 2 Part B Recoveries
69	Payout-Withhold Release	CB	PCG 2 AR CDR Hosp
71	Withhold-Encounter Data Unacceptable	DG	DRG Retro Review
72	Overage .99 or Less	DR	Deceased Member Recoupment
73	No Medicaid/Partnership Enrollment	IP	Impact Plus
74	Withhold-Provider Data Unacceptable	IR	Interest Payment
75	Withhold-PCP Data Unacceptable	CC	Converted Claim Credit Balance
76	Withhold-Other	MS	Prog Intre Post Pay Rev Cont C
77	A/R Member IPV	OR	On Demand Recoupment Refund
78	CAP Adjustment-Other	RP	Recoupment Payout
79	Member Not Eligible for DOS	RR	Recoupment Refund
80	Adhoc Adjustment Request	SC	SURS Contract
81	Adj Due to System Corrections	SS	State Share Only
82	Converted Adjustment	UA	DXC Technology Medicare Part A Recoup
83	Mass Adj Warr Refund	UB	DXC Technology Medicare Part B Reoup
84	DMS Mass Adj Request	XO	Reg. Psych. Crossover Refund
85	Mass Adj SURS Request		
86	Third Party Paid – TPL		
87	Claim Adjustment – TPL		
88	Beginning Dummy Recoupment Bal		
89	Ending Dummy Recoupment Bal		
90	Retro Rate Mass Adj		
91	Beginning Credit Balance		
92	Ending Credit Balance		
93	Beginning Dummy Credit Balance		
94	Ending Dummy Credit Balance		

## 11 Appendix E

### 11.1 Remittance Advice Status Code (ST CD)

The following is a one-character code indicating the status of the accounts receivable transaction:

A	Active
B	Hold Recoup - Payment Plan Under Consideration
C	Hold Recoup - Other
D	Other-Inactive-FFP-Not Reclaimed
E	Other – Inactive - FFP
F	Paid in Full
H	Payout on Hold
I	Involves Interest – Cannot Be Recouped
J	Hold Recoup Refund
K	Inactive-Charge off – FFP Not Reclaimed
P	Payout – Complete
Q	Payout – Set Up In Error
S	Active - Prov End Dated
T	Active Provider A/R Transfer
U	DXC Technology On Hold
W	Hold Recoup - Further Review
X	Hold Recoup - Bankruptcy
Y	Hold Recoup - Appeal
Z	Hold Recoup - Resolution Hearing

## 12 Appendix F

### 12.1 Procedural Coding for Title V Services Provided by DCBS

The following is a representative sample of codes and/or services that may be covered by KY Medicaid.

The procedure codes for Title V Services are as follows:

Targeted Case Management	T2023
Private Child Care/ Residential	99199
Group Home/ Residential	H0043
Day Treatment	H2012

These services are billed in a single monthly unit and do not require prior authorization.

Partial Comprehensive Evaluation	99244
Complete Comprehensive Evaluation	99245

These services are billed as one unit and do not require prior authorization.

Therapeutic Child Support	H2021	1 Unit equals 15 minutes
Individual Therapy	90804	1 Unit equals 15 minutes
Group Therapy	90853	1 Unit equals 15 minutes
Collateral	90887	1 Unit equals 15 minutes
Evaluation	T1023	1 Unit equals 1 hour
After School/ Summer Program	H2019	1 Unit equals 15 minutes

These services are billed in the appropriate units and require prior authorization.

For procedure codes H2021, 90804, 90853, 90887, T1023 and/or H2019 enter the sub-provider's nine (9) digit tax ID number. Enter the three (3) digit suffix, if applicable. For all other procedure codes, enter an alpha-numeric invoice number. The number must be at least 9 characters.

## 12.2 Modifier Codes

Valid modifiers are as follows:

Procedure	Modifier	Description
H2021	HM	Therapeutic Child Support Staff
H2021	HN	Therapeutic Child Support Staff Professional
H2021	HS	Family Couple or Parent to Parent
90804	U1	Psychiatrist
90804	None	Psychiatrist
H2019	None	Therapeutic Behavioral Service, Summer Program
H2019	UG	After School Program

## 13 Appendix G

### 13.1 Place of Service

03	School (effective date of service 7/1/15)
04	Homeless Shelter (effective date of service 7/1/15)
11	Office (effective date of service 7/1/15)
12	Home (effective date of service 7/1/15)
14	Group Home (effective date of service 7/1/15)
15	Mobile Unit (effective date of service 7/1/15)
16	Temporary Lodging (effective date of service 7/1/15)
19	Off Campus – Outpatient Hospital (Dates of service on or after 2/1/16)
20	Urgent Care Facility (effective date of service 7/1/15)
22	Outpatient Hospital (effective date of service 7/1/15)
23	Emergency Room (effective date of service 7/1/15)
49	Independent Clinic (effective date of service 7/1/15)
50	Federally Qualified Health Center (effective date of service 7/1/15)
53	Community Mental Health Center (effective date of service 7/1/15)
56	Psychiatric Residential Treatment Center (effective date of service 7/1/15)
57	Non-residential Substance Abuse Treatment Facility (effective date of service 7/1/15)
71	Public Health Clinic (effective date of service 7/1/15)
72	Rural Health Clinic (effective date of service 7/1/15)
99	Other (end dated 6/30/15)